Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____
Address:_____
Occupation:_____ Date of Birth: _____
Have you received massage therapy before? ☐ Yes ☐ No
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address. _____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above? ☐ Yes ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above? ☐ Yes ☐ No

Infections
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions
- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity to what? _____ type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, what? _____
- ☐ arthritis

is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women
- ☐ pregnant, due:_____
- ☐ gynaecological conditions, what?_____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____
_____

Current Medications:
_____
condition it treats: _____
_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____
_____

Surgery – date _____
nature: _____

Injury – date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
what? _____

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No
what? _____
where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____
_____

Notes:

Date of initial Health History:_____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

INFORMED CONSENT

Please read the following information thoroughly. If you have **ANY** questions, please do not hesitate to ask them.

As part of our profession's ongoing commitment to provide quality care, it is essential that you are fully aware and understand your rights, the treatment procedure, and any policies. This will assist you in making an informed choice in regard to massage therapy treatment.

Clients Rights:

- To determine what, if anything may be done to your body; you exercise this right by either giving or withholding your written informed consent.
- To refuse, modify, terminate treatment (or any aspect of treatment) at any time regardless of prior consent.
- If any of the following areas (inner thigh, gluteal/buttocks, abdomen or breasts) are to be included into your treatment, the therapeutic indication and treatment procedures will be discussed by the client and therapist. An additional verbal consent will be given by you, prior to undraping/treatment of the areas listed above.
- ALL client information (verbal and written) is confidential and will be safeguarded by the therapist, except for disclosure by law or order of the court. In this case, written authorization will be obtained prior to any communication concerning client records.
- Treatment will only be provided when there is reasonable expectation that it will be advantageous to the client.
- Draping defines a physical boundary which ensures the safety, comfort and privacy of the client. ***Only one area at a time, while being treated will be undraped.*** Being fully draped or clothed during a treatment is also an option. Please discuss your comfort level with your therapist.
- If the Registered Massage Therapist (RMT) feels that a referral to another health care professional is necessary, this will be discussed and accomplished with the clients consent.

Procedure: **the following will be discussed and agreed upon by the client and RMT.**

- Needs, assessment and treatment plan include: clients' health history form, assessment and examination procedures, treatment modalities, self care and remedial exercise suggestions. Periodic review of the above will be conducted.
- Any potential risks, benefits, positive or adverse effects, alternatives to the proposed treatment plan.

OVER PLEASE

FEE SCHEDULE

MASSAGE TREATMENT	REGULAR	STUDENT/SENIOR
30 minutes	$50.00	$45.00
45 minutes	$70.00	$65.00
60 minutes	$80.00	$75.00

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

Fees are due at the time of treatment. We accept payment by **cash** or **cheque.**
For **extended health care benefits:** you pay us for your treatment, we will then provide you with a receipt to submit to your insurance company for a reimbursement directly to yourself. If other financial arrangements are required, please discuss them with myself prior to treatment.

We require notification of cancellation of an appointment in advance. Without prior notification, you may be billed for the FULL PRICE of your appointment time.

CONSENT TO TREATMENT

I have read and fully understand all the information included in the consent document.

Anything that was unclear, was discussed and explained by the Registered Massage Therapist.

I confirm that I am capable of consenting to treatment.

I acknowledge that my consent is voluntary and I understand that I may withdraw my consent at any time.

I hereby understand the procedure of Massage Therapy that I will be receiving, to treat my presented condition. Therefore, I give consent to the Registered Massage Therapist to perform this treatment.

SIGNATURE:_____ **DATE:**_____